

TXCOMP

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Claim Details

General Claim Details

Claim Number

Field Office

HOUSTON WEST FIELD OFFICE

ΙE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status **Date Created**

Created By

Claim Received Date

Claim Established By

Carrier Claim Number

EDI_148

Lost Time

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC

MTC Date

08/22/2011

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date

Policy Number

07/01/2011 07/01/2012

Linkage Insurer Details

Insurer Name

COMMERCE & INDUSTRY INSURANCE CO

Insurer FEIN

131938623

Insurer Email

Insured Type

C

Business Name

Address Line 1

PO BOX 133677

Address Line 2

City State **AUSTIN** Texas

ZIP/Postal Code

78711

County Country Anderson **United States**

760031861

State/Province/Region

Linkage Employer Details

Linkage Employer Name

CENIKOR FOUNDATION INC

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number

Self Insured Indicator SIc Code

Business Name

4525 Glenwood Ave

Address Line 1

Address Line 2 City

Deer Park Texas

State **ZIP/Postal Code**

775367901 Harris

County Country

United States

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code **Fax Number**

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City State

ZIP/Postal Code Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

131938623

COMMERCE INDUSTRY US

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS

Texas

75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1

Address Line 2 City/Town

State

ZIP/Postal Code

Texas County

Country

Male

Married

Other

United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**



Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began?

Date of Injury Time of Injury **Date Reported to Employer**

Date of first work day

missed

Cause of Injury Category

Cause of Injury How the

injury/occupational disease occurred.

08/19/2011

Falling or Flying Object

WHILE STACKING WOOD ONE FELL OFF LINE HITTING EE

Did injured worker see No a doctor?

Date of Death

Cause of Death

Have you returned to work?

Provide the date you returned to work

If you have returned to work, what is your work status?

If you have returned to work, what is your wage status?

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

If accident occurred outside of Texas give County Name

If accident occurred outside of Texas, on what date did the injured worker leave Texas

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Toe(s)

Side Injured Finger or Toe Injured

Nature of Injury

Fracture - breaking of bone or cartilage

Witnesses

First Name

No information found

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name Supervisor's Last Name

Address Line 1

Address Line 2

City/Town

State
ZIP/Postal Code

Texas County Country

Country State / Drowless / S

State/Province/Region Phone Country Code Phone Area Code Phone Number Phone Extension

Fax Area Code Fax Number

Fax Country Code

Cenikor

4525 Glenwood Ave

Deer Park

Texas 775367901

United States

Occupation and Wage Information

Occupation at time of injury Date of Hire

WAREHOUSE

Was injured worker hired or

recruited in Texas?

On what date did injured worker

start this position?

Pay Period

Weekly 35000

Gross Wages per Pay Period

Hourly Rate

Number of hours per week

Days worked per week

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which

can be estimated in money?

Amount

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

Injured Worker Prior Marriage Details

First Name Last Name
No information found

Name Suffix Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bilis
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type **First Name Last Name Name Suffix** Social Security Number **Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name** Address Line 1 Address Line 2 City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region **Phone Type**

Phone Country Code

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status Date Created

Created By

Claim Received Date

Claim Established By

Carrier Claim Number

ΙE

HOUSTON WEST FIELD OFFICE

EDI_148

Medical Only

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC

MTC Date

05/22/2012

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date

Policy Expiration Date

Policy Number

07/01/2011 07/01/2012

Linkage Insurer Details

Insurer Name

COMMERCE & INDUSTRY INSURANCE CO

Insurer FEIN

131938623

Insurer Email

Insured Type

С

Business Name

Address Line 1

PO BOX 133677

Address Line 2

City

AUSTIN Texas

State **ZIP/Postal Code**

78711

County

Anderson

Country

State/Province/Region

United States

Linkage Employer Details

Linkage Employer Name

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number

Self Insured Indicator

Sic Code

Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code

County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1 Address Line 2

City

State ZIP/Postal Code

Texas County Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code Phone Number

Phone Extension

131938623

COMMERCE INDUSTRY US

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS Texas 75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents Race/Ethnicity

Primary Non-English Language

Address Line 1 Address Line 2

City/Town

State

ZIP/Postal Code Texas County

Country



















United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**

Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury Time of Injury Date Reported to Employer** Date of first work day missed **Cause of Injury** Category Cause of Injury Cumulative, Not Otherwise Classified - all other How the PSYCHOLOGICAL ABUSE injury/occupational disease occurred. Did injured worker see No a doctor? **Date of Death Cause of Death** Have you returned to work?

Provide the date you returned to work If you have returned to work, what is your work status? If you have returned to work, what is your wage status? **Address Business Name Address Line 1** Address Line 2 City/Town State ZIP/Postal Code **Texas County** State/Province/Region If accident occurred outside of Texas give County Name If accident occurred outside of Texas, on what date did the Injured worker leave

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Side Injured

Finger or Injured

Nature of Injury

All Other Cumulative Injuries, Not Otherwise Classified

Multiple Body Parts

Witnesses

First Name

Last Name

Cenikor

Houston

770792110

United States

Texas

11111 Katy Fwy Ste 500 FRWY

Name Suffix

No information found

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2

City/Town State

ZIP/Postal Code Texas County

Country

State/Province/Region

Phone Country Code

Phone Area Code

Phone Number Phone Extension

Fax Country Code

Fax Area Code

Fax Number

Occupation and Wage Information

Occupation at time of injury

Date of Hire

COUNSELOR

Was injured worker hired or

recruited in Texas?

On what date did injured worker

start this position?

Pay Period

Weekly 50000

Gross Wages per Pay Period

Hourly Rate

Number of hours per week

Days worked per week

. .

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which

can be estimated in money?

Amoun

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the

second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

Injured Worker Prior Marriage Details

First Name Last Name Name Suffix Date of Divorce. Date of Death Address
No information found

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type **First Name Last Name Name Suffix** Social Security Number **Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name** Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County** Country State/Province/Region **Phone Type Phone Country Code**

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

HOUSTON EAST FIELD OFFICE

ΙE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date Claim Established By

Carrier Claim Number

EDI_148

Lost Time

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC

00

MTC Date

05/05/2011

Linkage Carrier Representative Details

Carrier Box Number Carrier FEIN Carrier Name

Policy Details

Policy Effective Date Policy Expiration Date Policy Number

07/01/2010 07/01/2011

Linkage Insurer Details

Insurer Name

Insurer FEIN

Insurer Email

Insured Type

Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code

County

Country

State/Province/Region

Linkage Employer Details

Linkage Employer Name

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number

Self Insured Indicator

SIc Code

Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code

County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City **State**

ZIP/Postal Code

Texas County Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code

Phone Number

Phone Extension

131938623

COMMERCE INDUSTRY US

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS Texas 75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1 **Address Line 2**

City/Town

State

ZIP/Postal Code Texas County

Country









Single

Other





United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**



Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury** Time of Injury **Date Reported to Employer** Date of first work day missed **Cause of Injury** Category On Same Level **Cause of Injury** How the EE WAS WORKING WITH A MANDRIL injury/occupational disease occurred. Did injured worker see No a doctor? **Date of Death Cause of Death** Have you returned to work? Provide the date you returned to work If you have returned to work, what is your work status? If you have returned to work, what is your wage status? **Address Business Name** Address Line 1 Address Line 2 City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region If accident occurred outside of Texas give County Name If accident occurred outside of Texas, on what date did the Injured worker leave

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment? On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Side Injured Finger or Toe Injured

Nature of Injury

Low Back Area (Lumbar Area & Lumbo-

Strain

Witnesses

First Name

Last Name

Name Suffix

No information found

Claim Employer Information

Employer's (Company's) Name

Cenikor Fndtn

Supervisor's First Name Supervisor's Last Name

4525 Glenwood Ave

Address Line 1 Address Line 2

Deer Park

City/Town State

Texas

ZIP/Postal Code

775367901

Texas County

United States

Country State/Province/Region

Phone Country Code Phone Area Code Phone Number Phone Extension

Fax Country Code Fax Area Code

Fax Number

Occupation and Wage Information

Occupation at time of injury **Date of Hire**

LABORER

Was injured worker hired or

recruited in Texas?

On what date did injured worker start this position?

Pay Period

Weekly 35000

Gross Wages per Pay Period

Hourly Rate

Number of hours per week

Days worked per week

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the

second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last Name
No information found

Name Suffix

Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type **First Name Last Name Name Suffix Social Security Number Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name** Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County** Country State/Province/Region **Phone Type Phone Country Code**

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

HOUSTON EAST FIELD OFFICE

ΙE

Role Selected

Representative SubType Selected

Role Specific

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Filing Status Date Created

Created By

Claim Received Date

Claim Established By

Carrier Claim Number

EDI_148

Lost Time

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC

00

MTC Date

07/19/2011

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date 07/01/2010

Policy Number

07/01/2011

Linkage Insurer Details

Insurer Name

COMMERCE & INDUSTRY INSURANCE CO

Insurer FEIN

131938623

Insurer Email

C

Insured Type

Business Name Address Line 1

PO BOX 133677

Address Line 2

City

AUSTIN

State ZIP/Postal Code Texas 78711

County Country Anderson

State/Province/Region

United States

Linkage Employer Details

Linkage Employer Name

CENIKOR FOUNDATION INC

760031861

FEIN **Email**

Insured Location Number

Insured Name

Insured Reported Number Self Insured Indicator

Sic Code

Business Name

Address Line 1

4525 Glenwood Ave

Address Line 2

Deer Park Texas

City State

775367901

ZIP/Postal Code County

Harris **United States**

State/Province/Region

Phone Type

Country

Phone Country Code

Phone Area Code **Phone Number Phone Extension Fax Country Code** Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

710776041

Email

Insurer FEIN

131938623

Insurer Name

COMMERCE INDUSTRY US

TPA FEIN

132925174

TPA Name

AIG DOMESTIC CLAIMS INC.

Claim Admin Business Name

Address Line 1

1999 BRYANT ST. 24TH FLOOR

Address Line 2

DALLAS

City State

Texas

ZIP/Postal Code

Texas County

75201

Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code

Phone Number

Phone Extension

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Male Single

Gender

Marital Status Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Other

Primary Non-English Language

Address Line 1 Address Line 2

City/Town

State

ZIP/Postal Code **Texas** County

Country



United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**

Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury** Time of Injury **Date Reported to Employer** Date of first work day missed **Cause of Injury** Category Twisting **Cause of Injury** EE STEPPING OVER PALLET AND TWISTED ANKLE How the injury/occupational disease occurred. Did injured worker see No a doctor? **Date of Death** Cause of Death Have you returned to work? Provide the date you returned to work If you have returned to work, what is your work status? If you have returned to work, what is your wage status? **Address Business Name** Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County** Country State/Province/Region If accident occurred outside of Texas give County Name If accident occurred outside of Texas, on what date did the injured worker leave

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment? On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part Ankle - tarsals

Side Injured

Finger or Toe Injured

Nature of Injury

Sprain

Witnesses

First Name

No information found

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2

City/Town

State **ZIP/Postal Code**

Texas County

Country

State/Province/Region

Phone Country Code

Phone Area Code

Phone Number

Phone Extension Fax Country Code

Fax Area Code

Fax Number

Cenikor Fndtn

4525 Glenwood Ave

Deer Park

Texas

775367901

United States

Occupation and Wage Information

Occupation at time of injury **Date of Hire**

Was injured worker hired or recruited in Texas?

On what date did injured worker



start this position?

Pay Period

Weekly 35000

5

Gross Wages per Pay Period

Hourly Rate

Number of hours per week

Days worked per week

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?

Amount

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the

second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name

No information found

Last Name

Name Suffix

Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type
First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number

Jurisdiction
Green Card Number

Foreign ID

Country

Date of Birth

Address Business Name

Address Line 1

Address Line 2 City/Town

City/ It

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

FORT WORTH FIELD OFFICE

ΙE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date

Claim Established By

Carrier Claim Number

EDI_148

Medical Only

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC **MTC Date** 00

03/17/2016

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date 07/01/2015 07/01/2016

Policy Number

Linkage Insurer Details

Insurer Name

GRANITE STATE INSURANCE CO

Insurer FEIN

020140690

Insurer Email

Insured Type

С

Business Name

Address Line 1

PO Box 13367

Address Line 2

City

Austin

State

Texas 787113367

ZIP/Postal Code County

Travis

Country State/Province/Region **United States**

Linkage Employer Details

Linkage Employer Name

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number

Self Insured Indicator

Sic Code

Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code

County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code **Fax Number**

Claim Admin Details

Claim Admin Claim Number

710978841

Email

Insurer FEIN

020140690

Insurer Name

GRANITE STATE INSURANCE CO.

TPA FEIN

132925174

TPA Name

AIG CLAIMS INC

Claim Admin Business Name

Address Line 1

Address Line 2

1999 BRYANT ST. 24TH FLOOR

City

DALLAS

State

Texas 75201

ZIP/Postal Code Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Male

Gender

Single

Marital Status

Was injured worker married at the time of death?

Did injured worker have any prior

marriages? **Number of Dependents**

Race/Ethnicity

Other

Primary Non-English Language

Address Line 1

Address Line 2 City/Town

State

ZIP/Postal Code

Texas County

Country

United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**

Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury** Time of Injury **Date Reported to Employer** Date of first work day



Moving Parts of Machine

Cause of Injury Category **Cause of Injury**

missed

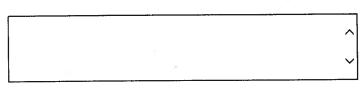
How the injury/occupational

disease occurred.

WHILE FEEDING A COMPUND INTO A PRESS MACHINE THOUGHT THE MACHINE WAS FINISHED AND WAS NOT

Did injured worker see No a doctor?

Date of Death Cause of Death



Have you returned to work?

Provide the date you returned to work

If you have returned to work, what is your work status?

If you have returned to work, what is your wage status?

Address Business Name Cenikor Fndtn

Address Line 1

2209 S Main St

Address Line 2

City/Town

Fort Worth

State

Texas

ZIP/Postal Code

761102110

Texas County

Country

United States

State/Province/Region If accident occurred

outside of Texas give County Name If accident occurred outside of Texas, on what date did the injured worker leave

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment? On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category **Injured Body Part**

Side Injured Finger or Toe Injured

Nature of Injury

Amputation

First Name

No information found

Witnesses

Last Name

Finger(s) - other than thumb

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Country Code

Phone Area Code Phone Number

Phone Extension

Fax Country Code

Fax Area Code

Fax Number

Cenikor Fndtn

2209 S Main St

Fort Worth

Texas

761102110

United States

Occupation and Wage Information

Occupation at time of injury

Date of Hire

Was injured worker hired or

recruited in Texas?

On what date did injured worker

UNKNOWN

start this position? **Pay Period Gross Wages per Pay Period Hourly Rate** Number of hours per week Days worked per week Did injured worker routinely work overtime? Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money? Frequency you were furnished this amount. Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County** Country State/Province/Region

Non-Claim Employer Contact

First Name Last Name Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job? Weekly amount of loss

Treating Doctor Information

First Name Last Name Name Suffix **Address Business Name Address Line 1** Address Line 2 City/Town State **ZIP/Postal Code Texas County**

Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name

No information found

Last Name

Name Suffix

Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type **First Name Last Name Name Suffix** Social Security Number **Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth** Address Business Name Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County** Country

State/Province/Region

Phone Type
Phone Country Code
Phone Area Code
Phone Number

Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

EDI_148

Role Selected

HOUSTON WEST FIELD OFFICE

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date

Claim Established By

Carrier Claim Number

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Medical Only

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Texas

Transaction Details

MTC

00

MTC Date

03/06/2017

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date 07/01/2016 07/01/2017

Policy Number

Linkage Insurer Details

Insurer Name

Aig Property Casualty Co

Insurer FEIN

251118791

C

Insurer Email Insured Type

Business Name

Address Line 1

PO Box 13367

Address Line 2

City State

Texas 787113367

Austin

ZIP/Postal Code County

Travis

Country

United States

State/Province/Region

Linkage Employer Details

Linkage Employer Name

CENIKOR FOUNDATION INC

760031861

FEIN **Email**

Insured Location Number

Insured Name

Insured Reported Number Self Insured Indicator

Sic Code

Business Name

Address Line 1

4525 Glenwood Ave

Address Line 2

City

Deer Park Texas

State **ZIP/Postal Code**

775367901 Harris

County Country

United States

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code **Fax Number**

Claim Admin Details

Claim Admin Claim Number

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1 **Address Line 2**

City

State

ZIP/Postal Code

Texas County Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code

Phone Number

Phone Extension

251118791

CHARTIS PROPERTY CASUALTY CO

132925174

AIG CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS Texas

75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1 Address Line 2

City/Town State

ZIP/Postal Code

Texas County

Country

Female

Married

Other

United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**



Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began?

Date of Injury Time of Injury

Date Reported to Employer

Date of first work day missed

Cause of Injury Category

Cause of Injury How the

injury/occupational disease occurred.

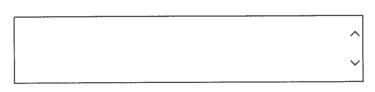
Fall, Slip, Trip, Not Otherwise Classified

WALKING IN FROM THE PARKING LOT AND SHE FELL AT THE FRONT ENTRANCE.

Did injured worker see No a doctor?

Date of Death

Cause of Death



Have you returned to work?

Provide the date you returned to work

If you have returned to work, what is your work status?

If you have returned to work, what is your wage status?

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

State/Province/Region

If accident occurred outside of Texas

give County Name If accident occurred outside of Texas, on what date did the injured worker leave Texas

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment? On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Skull

Side Injured Finger or **Injured**

Nature of Injury

Fracture - breaking of bone or cartilage

Witnesses

First Name

Last Name

Name Suffix

No information found

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name Supervisor's Last Name

Address Line 1

Address Line 2 City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Country Code

Phone Area Code

Phone Number

Phone Extension Fax Country Code

Fax Area Code

Fax Number

United States

Deer Park

775365999

Texas

Cenikor Foundation I

4525 Glenwood Ave

Occupation and Wage Information

Occupation at time of Injury

Date of Hire

NURSE

Was injured worker hired or

recruited in Texas? On what date did injured worker start this position? **Pay Period Gross Wages per Pay Period Hourly Rate** Number of hours per week Days worked per week Did injured worker routinely work overtime? Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money? Frequency you were furnished this amount. **Second Job**

Second Job Information

Non-Claim Employer

Employer's Business Name Address Line 1 Address Line 2 City/Town **State ZIP/Postal Code Texas County** Country State/Province/Region

Non-Claim Employer Contact

First Name Last Name Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job? Weekly amount of loss

Treating Doctor Information

First Name Last Name Name Suffix Address Business Name Address Line 1 Address Line 2 City/Town State

ZIP/Postal Code Texas County Country State/Province/Region **Phone Type Phone Country Code**

Phone Area Code

Phone Number

Phone Extension

Beneficiary Information

Last Name

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name

No information found

Name Suffix Date of Divorce **Date of Death**

Address

Medical and Burial Expenses

Total Medical Bills Amount of Unpaid Bills Was Autopsy Performed? Amount of Funeral Bill Has bill been paid? **Amount Paid** Paid by whom?(name)

Representative Information

Representative Type

First Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

FORT WORTH FIELD OFFICE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Created by

Claim Received Date

Claim Established By

Carrier Claim Number

EDI_148

Lost Time

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Texas

Transaction Details

MTC

00

MTC Date

09/11/2012

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date

Policy Number

07/01/2012 07/01/2013

Linkage Insurer Details

Insurer Name

COMMERCE & INDUSTRY INSURANCE CO

Insurer FEIN

131938623

Insurer Email

Insured Type

С

Business Name

Address Line 1

PO BOX 133677

Address Line 2

City

AUSTIN

State ZIP/Postal Code Texas 78711

County

Anderson

Country

760031861

State/Province/Region

United States

Linkage Employer Details

Linkage Employer Name

CENIKOR FOUNDATION INC

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number Self Insured Indicator

Sic Code

Business Name

Address Line 1

2209 S Main St

Address Line 2

City State Fort Worth Texas

ZIP/Postal Code

761102110

County

Tarrant **United States**

Country State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

131938623

COMMERCE INDUSTRY US

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS

Texas 75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1 Address Line 2

City/Town

State

ZIP/Postal Code Texas County

Country



Male

Single

Other



United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**



Claim Information You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury** Time of Injury **Date Reported to Employer** Date of first work day missed Cause of Injury Category **Cause of Injury** Machine or Machinery How the FINGERS PINCHED BWT STEEL DIE RESULTING IN BOTH injury/occupational HANDS GETTING CAUGHT IN THE BRAKE PRESS disease occurred. Did injured worker see No a doctor? **Date of Death Cause of Death** Have you returned to work? Provide the date you returned to work If you have returned to work, what is your work status? If you have returned to

work, what is your wage status? **Address Business Name** Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County** State/Province/Region If accident occurred outside of Texas give County Name If accident occurred outside of Texas, on what date did the Injured worker leave

Texas

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Multiple Upper Extremities

Side Injured

Finger or Toe Injured

Nature of Injury

Crushing

Witnesses

First Name

No information found

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country
State/Province/Region

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Fax Country Code

Fax Area Code

Fax Number

Cenikor Fndtn

2209 S Main St

Fort Worth

Texas

761102110

United States

Occupation and Wage Information

Occupation at time of injury

Date of Hire

Was injured worker hired or

recruited in Texas?

On what date did injured worker

MANUFACTURING

start this position?

Pay Period

Weekly

Gross Wages per Pay Period

50000

Hourly Rate

Number of hours per week

Days worked per week

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last
No information found

Last Name

Name Suffix

Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type **First Name Last Name Name Suffix Social Security Number Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name** Address Line 1 **Address Line 2** City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region

Phone Type

Phone Country Code Phone Area Code Phone Number **Phone Extension** License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

WACO FIELD OFFICE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date

Claim Established By

Carrier Claim Number

EDI_148

Medical Only

ΙE

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Texas

Transaction Details

мтс

MTC Date

08/01/2015

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date Policy Number

07/01/2015 07/01/2016

Linkage Insurer Details

Insurer Name

GRANITE STATE INSURANCE CO

Insurer FEIN

020140690

Insurer Email Insured Type

C

Business Name

Address Line 1

PO Box 13367

Address Line 2

City State

Austin Texas

ZIP/Postal Code County

787113367 Travis

Country

United States

State/Province/Region

Linkage Employer Details

Linkage Employer Name

Cenikor Fndtn 760031861

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number Self Insured Indicator

Sic Code

Business Name

Address Line 1

11111 Katy Fwy Ste 500

Address Line 2

City

Houston Texas

State **ZIP/Postal Code**

770792114 Harris

County

United States

Country State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code Texas County

Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code

Phone Number

Phone Extension

020140690

GRANITE STATE INSURANCE CO.

132925174

AIG CLAIMS INC

1999 BRYANT ST. 24TH FLOOR

DALLAS

Texas

75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Was injured worker married at the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1 Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country









Married

0





United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**



Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury Time of Injury Date Reported to Employer** Date of first work day



missed **Cause of Injury**

Category **Cause of Injury**

How the injury/occupational disease occurred.

Hand Tool, Utensil; Not Powered EE SHARPENING KNIFE CUT HAND

Did injured worker see No a doctor?

Date of Death Cause of Death



Have you returned to work? Provide the date you returned to work

If you have returned to work, what is your work status?

If you have returned to work, what is your wage status?

Address Business Name Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

If accident occurred outside of Texas give County Name

If accident occurred outside of Texas, on what date did the Injured worker leave Texas

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment? On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Hand - metacarpals and corresponding muscles

Side Injured

Finger or Injured

Nature of Injury

Laceration

Witnesses

First Name

No information found

Last Name

Cenikor Fndtn

11111 Katy Fwy

Houston

770792114

United States

Texas

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2

City/Town

State ZIP/Postal Code

Texas County

Country State/Province/Region

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Fax Country Code

Fax Area Code

Fax Number

Occupation and Wage Information

Occupation at time of injury

Date of Hire

COOK

Was injured worker hired or

recruited in Texas? On what date did injured worker start this position? **Pay Period Gross Wages per Pay Period Hourly Rate** Number of hours per week Days worked per week Did injured worker routinely work overtime? Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money? Frequency you were furnished this amount. **Second Job**

Second Job Information

Non-Claim Employer

Employer's Business Name Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County** Country State/Province/Region

Non-Claim Employer Contact

First Name Last Name Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job? Weekly amount of loss

Treating Doctor Information

First Name Last Name Name Suffix Address Business Name Address Line 1 **Address Line 2** City/Town State

ZIP/Postal Code Texas County Country State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension**

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name No information found

Last Name

Name Suffix

Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bills Amount of Unpaid Bills Was Autopsy Performed? Amount of Funeral Bill Has bill been paid? **Amount Paid** Paid by whom?(name)

Representative Information

Representative Type

First Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

DALLAS FIELD OFFICE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date Claim Established By

Carrier Claim Number

EDI_148

Lost Time

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Texas

Transaction Details

MTC

MTC Date

08/08/2012

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date 07/01/2011 07/01/2012

Policy Number

Linkage Insurer Details

Insurer Name

COMMERCE & INDUSTRY INSURANCE CO

Insurer FEIN

Insurer Email

131938623

Insured Type

Business Name

С

Address Line 1

PO BOX 133677

Address Line 2

City

AUSTIN

State ZIP/Postal Code Texas 78711

County Country Anderson **United States**

760031861

State/Province/Region

Linkage Employer Details

Linkage Employer Name

Cenikor Foundation Inc

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number Self Insured Indicator

Sic Code

Business Name

Address Line 1

11111 Katy Fwy Ste 500 Ste 535

Address Line 2

City State Houston Texas

ZIP/Postal Code

770792110

County

Harris

Country

United States

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City State

ZIP/Postal Code **Texas County**

Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code

Phone Number Phone Extension 131938623

COMMERCE INDUSTRY US

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS Texas 75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1 Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

Male



Single

Other



United States

State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension
Email Address



Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury** Time of Injury **Date Reported to Employer** Date of first work day missed **Cause of Injury** Category Lifting **Cause of Injury** How the EE WAS LIFTING A HANGER PLATE injury/occupational disease occurred. Did injured worker see No a doctor? **Date of Death Cause of Death** Have you returned to work? Provide the date you returned to work If you have returned to work, what is your work status? If you have returned to work, what is your wage status? **Address Business Name** Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County** Country State/Province/Region If accident occurred outside of Texas give County Name If accident occurred outside of Texas, on what date did the injured worker leave

Texas

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Side Injured Finger or Toe Injured

Nature of Injury

Low Back Area (Lumbar Area & Lumbo-Sacral)

Strain

Witnesses

No information found

First Name

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

company s) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Country Code

Phone Area Code

Phone Number

Phone Extension Fax Country Code

Fax Area Code

Fax Number

Occupation and Wage Information

Occupation at time of injury

Date of Hire

WELDER

4201 JANADA

HALLOM CITY

United States

Texas

76107

Was injured worker hired or

recruited in Texas? On what date did injured worker start this position?

Pay Period

Weekly

Gross Wages per Pay Period

50000

Hourly Rate

Number of hours per week

Days worked per week

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last Name
No information found

Name Suffix

Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type **First Name Last Name Name Suffix Social Security Number Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name** Address Line 1 Address Line 2 City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region **Phone Type Phone Country Code**

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

FORT WORTH FIELD OFFICE

ΙE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date

Claim Established By

Carrier Claim Number

EDI_148

Medical Only

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC

00

MTC Date

08/03/2016

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date 07/01/2016

Policy Number

07/01/2017

Linkage Insurer Details

Insurer Name

Aig Property Casualty Co

Insurer FEIN

Insurer Email Insured Type

C

Business Name

Address Line 1

PO Box 13367

251118791

Address Line 2

City

Austin

State ZIP/Postal Code Texas 787113367

County

Travis

Country

United States

State/Province/Region

Linkage Employer Details

Linkage Employer Name

Cenikor Fndtn 760031861

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number Self Insured Indicator

Sic Code

City

Business Name

Address Line 1

11111 Katy Fwy Ste 500

Address Line 2

Houston Texas

State **ZIP/Postal Code**

770792114 Harris

County Country

United States

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code **Fax Number**

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

251118791

CHARTIS PROPERTY CASUALTY CO

132925174

AIG CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS

Texas 75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language Address Line 1

Address Line 2 City/Town

State

ZIP/Postal Code Texas County

Country

Female

Married

٥

Other



United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**



Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began?

Date of Injury

Time of Injury

Date Reported to Employer Date of first work day

missed

Cause of Injury Category

Cause of Injury

How the injury/occupational disease occurred.



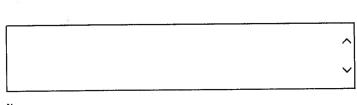
From Different Level (Elevation) - off wall, catwalk, bridge, etc.

SHE STATED THAT SHE HAD TRIPPED AND FALLEN DOWN SOME STAIRS. TURNING HER ANKLE AND SCRAPING HER ARM.

Did injured worker see No a doctor?

Date of Death

Cause of Death



Have you returned to work?

Provide the date you returned to work

If you have returned to work, what is your work status?

If you have returned to work, what is your wage status?

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

If accident occurred outside of Texas give County Name

If accident occurred outside of Texas, on what date did the Injured worker leave

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Parts

Side Injured Finger or Toe Injured

Nature of Injury

All Other Specific Injuries, Not Otherwise

Multiple Body

Witnesses

First Name

No information found

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Country Code Phone Area Code

Phone Number

Phone Extension

Fax Country Code

Fax Area Code

Fax Number

Occupation and Wage Information

Occupation at time of injury

Date of Hire

ADMIN ASSISTANT

Cenikor Foundation I

Houston

770792144

United States

Texas

11111 Katy Fwy Ste 500

Was injured worker hired or

recruited in Texas? On what date did injured worker start this position? **Pay Period Gross Wages per Pay Period Hourly Rate** Number of hours per week Days worked per week Did injured worker routinely work overtime? Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money? **Amount** Frequency you were furnished this amount. Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County** Country State/Province/Region

Non-Claim Employer Contact

First Name Last Name Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job? Weekly amount of loss

Treating Doctor Information

First Name **Last Name** Name Suffix **Address Business Name** Address Line 1 Address Line 2 City/Town State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number

Beneficiary Information

(no beneficiaries)

Phone Extension

Injured Worker Prior Marriage Details

First Name Last Name Name Suffix Date of Divorce Date of Death Address
No information found

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type **First Name Last Name** Name Suffix Social Security Number **Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name Address Line 1 Address Line 2** City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region **Phone Type Phone Country Code**

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

WACO FIELD OFFICE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date

Claim Established By

Carrier Claim Number

EDI_148

Lost Time

ΙE

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

atus

Agreement to Compensate Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC

MTC Date

10/24/2013

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date

Policy Expiration Date

Policy Number

07/01/2013 07/01/2014

Linkage Insurer Details

Insurer Name

GRANITE STATE INSURANCE CO

Insurer FEIN

Insurer Email

020140690

Insured Type

С

Business Name

Address Line 1

PO Box 13367

Address Line 2

City

Austin

State

Texas 787113367

ZIP/Postal Code

Travis

County

United States

Country

State/Province/Region

Linkage Employer Details

Linkage Employer Name

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number

Self Insured Indicator

SIc Code

Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code

County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code **Fax Number**

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City State

ZIP/Postal Code

Texas County Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code

Phone Number

Phone Extension

020140690

GRANITE STATE INSURANCE CO.

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS Texas 75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country **Date of Birth**

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1 Address Line 2

City/Town State

ZIP/Postal Code Texas County

Country

Female Married

Other



United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**

Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury** Time of Injury **Date Reported to Employer** Date of first work day missed **Cause of Injury** Category **Cause of Injury** How the injury/occupational disease occurred.

Strain or Injury By, Not Otherwise Classified

EE FOUND FACE UP ON THE FLOOR IN BREAKROOM NONRESPONSIVE

Did injured worker see No a doctor?

Date of Death Cause of Death

Have you returned to work?

Provide the date you returned to work

10/14/2013

If you have returned to work, what is your work status?

If you have returned to work, what is your wage status?

Address Business Name

Address Line 2 City/Town

Address Line 1

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

If accident occurred outside of Texas give County Name

If accident occurred outside of Texas, on what date did the Injured worker leave Texas

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Side Injured Finger or Toe Injured

Nature of Injury

Strain

Soft Tissue - other than larynx or trachea

Witnesses

First Name

No information found

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Fax Country Code

Fax Area Code

Fax Number

767083238

United States

Waco

Texas

Cenikor Foundation Inc

3015 Herring Ave

Occupation and Wage Information

Occupation at time of injury Date of Hire

BEHAVIORAL HEALTH TECH

Was injured worker hired or

recruited in Texas? On what date did injured worker start this position? **Pay Period Gross Wages per Pay Period Hourly Rate** Number of hours per week Days worked per week Did injured worker routinely work overtime? Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money? Amount Frequency you were furnished this amount. **Second Job**

Second Job Information

Non-Claim Employer

Employer's Business Name Address Line 1 Address Line 2 City/Town **State ZIP/Postal Code Texas County** Country State/Province/Region

Non-Claim Employer Contact

First Name Last Name Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job? Weekly amount of loss

Treating Doctor Information

First Name Last Name Name Suffix Address Business Name Address Line 1 Address Line 2 City/Town State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last Name No information found

Name Suffix

Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type **First Name Last Name Name Suffix Social Security Number Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name Address Line 1** Address Line 2 City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region **Phone Type Phone Country Code**

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behaif of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

HOUSTON WEST FIELD OFFICE

ΙE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date

Claim Established By

EDI_148

Medical Only

Employer's First Report Injury/Fatality

Carrier Claim Number

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC

MTC Date

03/31/2017

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date 07/01/2016

Policy Number

07/01/2017

Linkage Insurer Details

Insurer Name

Aig Property Casualty Co

Insurer FEIN

251118791

Insurer Email Insured Type

C

Business Name

Address Line 1

PO Box 13367

Address Line 2

Austin

City State

Texas 787113367

ZIP/Postal Code County

Travis

Country

United States

760031861

State/Province/Region

Linkage Employer Details

Linkage Employer Name

CENIKOR FOUNDATION INC

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number Self Insured Indicator

SIc Code

City

Business Name

Address Line 1

4525 Glenwood Ave

Address Line 2

Deer Park

State **ZIP/Postal Code** Texas 775367901

County

Harris

Country

United States

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN Insurer Name TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1 Address Line 2

City State

ZIP/Postal Code Texas County

Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code Phone Number Phone Extension

251118791 AIG CASUALTY 132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS Texas 75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID Country

Date of Birth

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1 Address Line 2

City/Town State

ZIP/Postal Code Texas County

Country









Not Reported

0 Other



United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**



Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury** Time of Injury **Date Reported to Employer** Date of first work day missed **Cause of Injury** Category Object Handled by Others **Cause of Injury** ANOTHER INDIVIDUAL THREW A BOX IN THE BACK OF A injury/occupational TRUCK AND STRUCK THE INJURED INDIVIDUALS LEG. disease occurred. Did injured worker see No a doctor? **Date of Death Cause of Death** Have you returned to

work? Provide the date you returned to work If you have returned to work, what is your work status? If you have returned to work, what is your wage status? **Address Business Name** Address Line 1 Address Line 2 City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region If accident occurred outside of Texas give County Name If accident occurred outside of Texas, on what date did the

injured worker leave

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Knee - patella

Side Injured Finger or Toe Injured

Nature of Injury

Contusion-bruise-intact skin surface, hematoma

Witnesses

First Name

No information found

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2 City/Town

State
ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Country Code Phone Area Code

Phone Number

Phone Extension

Fax Country Code

Fax Area Code

Fax Number

Cenikor Foundation I

4525 Glenwood Ave

Deer Park Texas

775365999

United States

Occupation and Wage Information

Occupation at time of injury

Date of Hire

LABORER

Was injured worker hired or

recruited in Texas? On what date did injured worker start this position?

Pay Period

Weekly 26110

Gross Wages per Pay Period

Hourly Rate

Number of hours per week

Days worked per week

5

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the

second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last Name I No information found

Name Suffix Date of Divorce

Date of Death

Address

ito illiorilladori todria

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type **First Name Last Name** Name Suffix **Social Security Number Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name Address Line 1 Address Line 2** City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region **Phone Type**

Phone Country Code

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

HOUSTON WEST FIELD OFFICE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date

Claim Established By

EDI_148

Medical Only

Employer's First Report Injury/Fatality

Carrier Claim Number

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC

MTC Date

03/07/2013

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date 07/01/2012

Policy Number

07/01/2013

Linkage Insurer Details

Insurer Name

COMMERCE & INDUSTRY INSURANCE CO

Insurer FEIN

Insurer Email

С

Insured Type Business Name

Address Line 1

PO BOX 133677

131938623

Address Line 2

City

AUSTIN

State ZIP/Postal Code Texas 78711

County Country

Anderson **United States**

760031861

State/Province/Region

Linkage Employer Details

Linkage Employer Name

CENIKOR FOUNDATION INC

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number Self Insured Indicator

Sic Code

City

Business Name

Address Line 1

4525 Glenwood Ave

Address Line 2

Deer Park Texas

State ZIP/Postal Code

775367901

County

Harris

Country

United States

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN TPA Name

Claim Admin Business Name Address Line 1

Address Line 2

City

State

ZIP/Postal Code Texas County

Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code

Phone Number

Phone Extension

131938623

COMMERCE INDUSTRY US

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS Texas

75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1

Address Line 2 City/Town

State

ZIP/Postal Code

Texas County

Country























United States

State/Province/Region Phone Type **Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**



Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative?

If yes, date

representation began?

Date of Injury Time of Injury

Date Reported to

Employer

Date of first work day missed

Cause of Injury Category

Cause of Injury

injury/occupational disease occurred.

Cut, Puncture, Scrape, Not Otherwise Classified

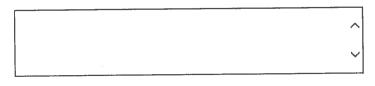
EMPLOYEE WAS HOOKING UP TRAILER AND SMASHED HAND WITH FORKLIFT

Did injured worker see No

a doctor?

Date of Death

Cause of Death



Have you returned to

work?

Provide the date you returned to work

If you have returned to work, what is your work status?

If you have returned to work, what is your wage status?

Address Business Name Cenikor Foundation Inc

Address Line 1

4525 Glenwood Ave

Address Line 2

City/Town

Deer Park

State

Texas

ZIP/Postal Code

775365999

Texas County

Country

United States

State/Province/Region

If accident occurred outside of Texas give County Name

If accident occurred outside of Texas, on what date did the injured worker leave

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?
On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Side Injured Finger or Toe Injured

Nature of Injury

Laceration

Hand - metacarpals and corresponding

Witnesses

No information found

First Name

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Fax Country Code

Fax Area Code

Fax Number

Cenikor Foundation Inc

4525 Glenwood Ave

Deer Park

Texas

775365999

United States

Occupation and Wage Information

Occupation at time of injury

Date of Hire

LABORER

Was injured worker hired or

recruited in Texas? On what date did injured worker start this position?

Pay Period

Weekly

Gross Wages per Pay Period

50000

Hourly Rate

Number of hours per week

Days worked per week

5

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last
No information found

Last Name

Name Suffix

Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type

First Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

HOUSTON EAST FIELD OFFICE

ΙE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date

Claim Established By

EDI_148

Employer's First Report Injury/Fatality

Carrier Claim Number

Claim Status Details

Claim Type

Claim Status

Lost Time

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Transaction Details

MTC

MTC Date

11/24/2010

Linkage Carrier Representative Details

Carrier Box Number Carrier FEIN

Carrier Name

Policy Details

Policy Effective Date Policy Expiration Date Policy Number

07/01/2010 07/01/2011

Linkage Insurer Details

Insurer Name

Insurer FEIN

Insurer Email

Insured Type

Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code

County

Country

State/Province/Region

Linkage Employer Details

Linkage Employer Name

FEIN

Emali

Insured Location Number

Insured Name

Insured Reported Number

Self Insured Indicator

Sic Code

Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code

County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1 Address Line 2

City State

ZIP/Postal Code

Texas County Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code

Phone Number

Phone Extension

131938623

COMMERCE INDUSTRY US

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS

Texas

75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Female Married

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1 Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

Other



United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension**

Email Address



Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury Time of Injury Date Reported to Employer** Date of first work day missed **Cause of Injury** Category Into Openings - shafts, excavations, floor openings, etc. **Cause of Injury** How the EMP FELL IN HALLWAY injury/occupational disease occurred. Did injured worker see No a doctor? **Date of Death Cause of Death** Have you returned to work? Provide the date you returned to work If you have returned to work, what is your work status? If you have returned to work, what is your wage status? Address Business Name Cenikor Foundation Inc 7676 Hillmont St Ste 190 Address Line 1 Address Line 2 City/Town Houston State Texas ZIP/Postal Code 770406467 **Texas County** Country **United States** State/Province/Region If accident occurred outside of Texas give County Name If accident occurred outside of Texas, on what date did the

injured worker leave

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body PartMultiple Body Parts

Side Injured

Finger or Toe Injured

Nature of Injury

Strain

Witnesses

First Name

No information found

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1 Address Line 2

City/Town

State
ZIP/Postal Code

Texas County

Country State/Province/Region

Phone Country Code Phone Area Code Phone Number

Phone Extension Fax Country Code Fax Area Code

Fax Number

Cenikor Foundation Inc

7676 Hillimont St Ste 190

Houston Texas

770406467

United States

Occupation and Wage Information

Occupation at time of injury Date of Hire

Was injured worker hired or

recruited in Texas?

On what date did injured worker

COUNSELOR

start this position?

Pay Period

Weekly 45560

5

Gross Wages per Pay Period

Hourly Rate

Number of hours per week

Days worked per week

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which

can be estimated in money?

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the

second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension**

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last Name **Name Suffix**

Date of Divorce

Date of Death

Address

No information found

Medical and Burial Expenses

Total Medical Bills Amount of Unpaid Bills Was Autopsy Performed? Amount of Funeral Bill Has bill been paid? **Amount Paid** Paid by whom?(name)

Representative Information

Representative Type First Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

HOUSTON WEST FIELD OFFICE

ΙE

Role Selected

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date Claim Established By

EDI_148

Medical Only

Employer's First Report Injury/Fatality

Carrier Claim Number

Claim Status Details

Claim Type

Claim Status

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Texas

Transaction Details

MTC

00

MTC Date

04/02/2012

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date 07/01/2011

Policy Number

07/01/2012

Linkage Insurer Details

Insurer Name

COMMERCE & INDUSTRY INSURANCE CO

Insurer FEIN

131938623

Insurer Email

С

Insured Type Business Name

PO BOX 133677

Address Line 1 Address Line 2

AUSTIN

City State **ZIP/Postal Code**

Texas 78711

County Country Anderson **United States**

760031861

State/Province/Region

Linkage Employer Details

Linkage Employer Name

Cenikor Foundation Inc

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number Self Insured Indicator

Sic Code

Business Name

Address Line 1

7676 Hillmont St Ste 190

Address Line 2

Houston Texas

City State

770406467 Harris

ZIP/Postal Code County

United States

Country State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code **Fax Number**

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code

Phone Number

Phone Extension

131938623

COMMERCE INDUSTRY US

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS

Texas 75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code Texas County

Country

Female

Married

Other

United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address**

Claim Information

You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury Time of Injury Date Reported to Employer** Date of first work day missed **Cause of Injury** Category On Same Level Cause of Injury SLIPPED AT DOOR AND STRUCK DOOR FRAME injury/occupational disease occurred. Did injured worker see No a doctor? **Date of Death** Cause of Death Have you returned to work?

Provide the date you returned to work If you have returned to work, what is your work status?

If you have returned to work, what is your wage status?

Address Business Name Cenikor Fndtn Address Line 1 11111 Katy Fwy

Address Line 2

City/Town

Houston Texas

State

ZIP/Postal Code

770792114

Texas County

Country

United States

State/Province/Region If accident occurred

outside of Texas give County Name

If accident occurred outside of Texas, on what date did the injured worker leave Texas

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment?

On what date was injured worke

On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part

Side Injured Finger or Toe Injured

Nature of Injury

Shoulder(s) - Armpit, Rotator Cuff, Trapezius, Clavicle, Scapula Contusion-bruise-intact skin surface, hematoma

Witnesses

First Name

No information found

Last Name

Cenikor Fndtn

11111 Katy Fwy

Houston

770792114

United States

Texas

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Fax Country Code

Fax Area Code Fax Number

Occupation and Wage Information

Occupation at time of injury

Date of Hire

COUNSELOR

Was injured worker hired or

recruited in Texas?

On what date did injured worker

start this position?

Pay Period

Weekly

Gross Wages per Pay Period

45560

Hourly Rate

Number of hours per week

Days worked per week

2

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?

Amount

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the

second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

Address

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last Name Name Suffix Date of Divorce Date of Death No information found

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type First Name Last Name Name Suffix Social Security Number Driver License/ID Number Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name** Address Line 1 Address Line 2 City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region **Phone Type Phone Country Code**

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

HOUSTON EAST FIELD OFFICE

Role Selected

ΙE

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Created By

Claim Received Date

Claim Established By

EDI_148

Employer's First Report Injury/Fatality

Carrier Claim Number

Claim Status Details

Claim Type

Claim Status

Lost Time

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Texas

Transaction Details

MTC

MTC Date

11/14/2012

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date 07/01/2012

Policy Number

07/01/2013

Linkage Insurer Details

Insurer Name

COMMERCE & INDUSTRY INSURANCE CO

Insurer FEIN

131938623

Insurer Email Insured Type

С

Business Name

Address Line 1

PO BOX 133677

Address Line 2

City

AUSTIN

State ZIP/Postal Code

Texas 78711

County Country Anderson **United States**

State/Province/Region

Linkage Employer Details

Linkage Employer Name

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number

Self Insured Indicator

SIc Code

Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code

County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code **Fax Number**

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

131938623

COMMERCE INDUSTRY US

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS Texas

75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No

marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1 Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

Female

Single

Other

United States

State/Province/Region Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension Email Address

State/Province/Region
If accident occurred
outside of Texas
give County Name
If accident occurred
outside of Texas,
on what date did the
injured worker leave

Texas



Claim Information You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury** Time of Injury **Date Reported to Employer** Date of first work day missed **Cause of Injury** Category Fall, Slip, Trip, Not Otherwise Classified **Cause of Injury** IW TRIPPED FELL OVER LUGGAGE PLACED IN HALLWAY injury/occupational disease occurred. Did injured worker see No a doctor? **Date of Death Cause of Death** Have you returned to work? Provide the date you returned to work If you have returned to work, what is your work status? If you have returned to work, what is your wage status? **Address Business Name** Address Line 1 Address Line 2 City/Town State **ZIP/Postal Code Texas County** Country

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment? On what date was injured worker last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part Knee - patella

Side Injured Finger or Toe Injured

Nature of Injury

Contusion-bruise-intact skin surface. hematoma

Witnesses

First Name

No information found

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1

Address Line 2 City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Fax Country Code

Fax Area Code

Fax Number

Deer Park

Cenikor Foundation Inc.

4525 Glenwood Ave

Texas

775365999

United States

Occupation and Wage Information

Occupation at time of injury

Date of Hire

FACILITY NURSE

Was injured worker hired or

recruited in Texas?

On what date did injured worker start this position?

Pay Period

Weekly 50000

Gross Wages per Pay Period

Hourly Rate

Number of hours per week

Days worked per week

Did injured worker routinely work

overtime?

Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money?

Frequency you were furnished

this amount.

Second Job

Second Job Information

Non-Claim Employer

Employer's Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Non-Claim Employer Contact

First Name

Last Name

Phone Type

Phone Country Code

Phone Area Code

Phone Number

Phone Extension

Non-Claim Wage

Is there a loss of wages from the

second job?

Weekly amount of loss

Treating Doctor Information

First Name

Last Name

Name Suffix

Address Business Name

Address Line 1

Address Line 2

City/Town

State

ZIP/Postal Code
Texas County
Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last
No information found

Last Name

Name Suffix I

Date of Divorce

Date of Death

Address

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Type

Representative Information

First Name
Last Name
Name Suffix
Social Security Number
Driver License/ID Number
Jurisdiction
Green Card Number
Foreign ID
Country
Date of Birth
Address Business Name
Address Line 1
Address Line 2

City/Town State

ZIP/Postal Code

Texas County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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Claim Details

General Claim Details

Claim Number

Field Office

HOUSTON WEST FIELD OFFICE

Role Selected

ΙE

Representative SubType Selected

Role Specific

Filed By

Filing Status

Date Created

Created By

Claim Received Date

Claim Established By

Carrier Claim Number

EDI_148

Employer's First Report Injury/Fatality

Claim Status Details

Claim Type

Claim Status

Lost Time

Agreement to Compensate

Late Reason Code

Date of Representation

Representative Type

Number Var Segment Details

Number of Benefit Adjustments

Number of Death Dependent

Payee

Number of Payment Adjustments

Number of Perm Impairments

Number of Ptd Red Earnings

Recoveries

Jurisdiction Details

Agency Claim Number

Jurisdiction

Texas

Transaction Details

MTC

იი

MTC Date

05/09/2014

Linkage Carrier Representative Details

Carrier Box Number

Carrier FEIN

741727735

Carrier Name

Flahive Ogden & Latson

Policy Details

Policy Effective Date Policy Expiration Date

07/01/2013 07/01/2014

Policy Number

Linkage Insurer Details

Insurer Name

GRANITE STATE INSURANCE CO

Insurer FEIN

020140690

Insurer Email

Insured Type

С

Business Name

Address Line 1

PO Box 13367

Address Line 2

City

Austin Texas

State ZIP/Postal Code

787113367

County

Travis

Country

United States

State/Province/Region

Linkage Employer Details

Linkage Employer Name

FEIN

Email

Insured Location Number

Insured Name

Insured Reported Number

Self Insured Indicator

Sic Code

Business Name

Address Line 1

Address Line 2

City

State

ZIP/Postal Code

County

Country

State/Province/Region

Phone Type

Phone Country Code

Phone Area Code Phone Number Phone Extension Fax Country Code Fax Area Code Fax Number

Claim Admin Details

Claim Admin Claim Number

Email

Insurer FEIN

Insurer Name

TPA FEIN

TPA Name

Claim Admin Business Name

Address Line 1

Address Line 2

City State

ZIP/Postal Code

Texas County Country

State/Province/Region

Phone Type

Phone Country Code Phone Area Code Phone Number

Phone Extension

020140690

GRANITE STATE INSURANCE CO.

132925174

AIG DOMESTIC CLAIMS INC.

1999 BRYANT ST. 24TH FLOOR

DALLAS Texas 75201

Injured Worker Personal Information

First Name

Middle Name

Last Name

Name Suffix

Social Security Number

Driver License/ID Number

Jurisdiction

Green Card Number

Foreign ID

Country

Date of Birth

Gender

Marital Status

Was injured worker married at

the time of death?

Did injured worker have any prior No marriages?

Number of Dependents

Race/Ethnicity

Primary Non-English Language

Address Line 1

Address Line 2 City/Town

ZIP/Postal Code

Texas County

Country

Male

Single

Other

United States

State/Province/Region **Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension**

Email Address



Claim Information You are reporting an Are you represented by an Attorney or Lay Representative? If yes, date representation began? **Date of Injury Time of Injury Date Reported to Employer** Date of first work day missed **Cause of Injury** Category Object Being Lifted or Handled **Cause of Injury** EE MOVING MATERIAL W DOLLY AND STRUCK IN HEAD BY How the injury/occupational DOLLY disease occurred. Did injured worker see No a doctor? **Date of Death** Cause of Death Have you returned to work? Provide the date you returned to work If you have returned to work, what is your work status? If you have returned to work, what is your wage status?

Address Business Name Address Line 1 **Address Line 2** City/Town State ZIP/Postal Code **Texas County** Country State/Province/Region If accident occurred outside of Texas give County Name If accident occurred outside of Texas, on what date did the Injured worker leave Texas

Occupational Disease/Repetitive Trauma

On what date did it first become known that the occupational disease or condition may be related to employment? On what date was injured worker

last exposed to the cause of the occupational disease or repetitive trauma?

Injury Details

One item found.

Injured Body Category

Injured Body Part Multiple Head Injury

Side Injured

Finger or Toe Injured

Nature of Injury

Laceration

Witnesses

First Name

No Information found

Last Name

Name Suffix

Claim Employer Information

Employer's (Company's) Name

Supervisor's First Name

Supervisor's Last Name

Address Line 1 Address Line 2

City/Town

State

ZIP/Postal Code

Texas County

Country

State/Province/Region **Phone Country Code**

Phone Area Code

Phone Number

Phone Extension

Fax Country Code

Fax Area Code

Fax Number

Cenikor Fndtn

4525 Glenwood Ave

Deer Park

Texas

775365999

United States

Occupation and Wage Information

Occupation at time of injury

Date of Hire

Was injured worker hired or

recruited in Texas?

On what date did injured worker



start this position? **Pay Period Gross Wages per Pay Period Hourly Rate** Number of hours per week Days worked per week 5 Did injured worker routinely work overtime? Was injured worker provided with health insurance, meals, rent, laundry, fuel or other items which can be estimated in money? Frequency you were furnished this amount. **Second Job**

Second Job Information

Non-Claim Employer

Employer's Business Name Address Line 1 **Address Line 2** City/Town **State ZIP/Postal Code Texas County** Country State/Province/Region

Non-Claim Employer Contact

First Name Last Name Phone Type Phone Country Code Phone Area Code Phone Number Phone Extension

Non-Claim Wage

Is there a loss of wages from the second job? Weekly amount of loss

Treating Doctor Information

First Name Last Name Name Suffix Address Business Name Address Line 1 Address Line 2 City/Town State ZIP/Postal Code **Texas County**

Country
State/Province/Region
Phone Type
Phone Country Code
Phone Area Code
Phone Number
Phone Extension

Beneficiary Information

(no beneficiaries)

Injured Worker Prior Marriage Details

First Name Last Name

e Name Suffix

Date of Divorce

Date of Death

Address

No information found

Medical and Burial Expenses

Total Medical Bills
Amount of Unpaid Bills
Was Autopsy Performed?
Amount of Funeral Bill
Has bill been paid?
Amount Paid
Paid by whom?(name)

Representative Information

Representative Type First Name Last Name Name Suffix Social Security Number **Driver License/ID Number** Jurisdiction **Green Card Number** Foreign ID Country **Date of Birth Address Business Name** Address Line 1 Address Line 2 City/Town State **ZIP/Postal Code Texas County** Country State/Province/Region **Phone Type**

Phone Country Code Phone Area Code Phone Number **Phone Extension** License Number Firm Name

Filed On Behalf Information

Name of Person Acting on Behalf of Injured Worker Name of Person Acting on Behalf of Beneficiary

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